C+D

WWW.CHEMISTANDDRUGGIST.CO.UK

30 October 2010

'Ride the wave'

Pharmacy must get on board with Lansley's NHS reforms, warns political chief page 4

CPD ZONE

helps keep back pain locked away for up to 12 hours

Nurofen Back Pain 300mg Sustained release Capsules

Why Nurofen. Thanks to its specifically formulated ibuprofen grains, Nurofen Back Pain 300mg Sustained Release Capsules are slowly absorbed by the body providing long lasting relief, for up to twelve hours. To find out more about how Nurofen helps to send back pain packing visit whynurofen.com

Name and active: Nurofen Back Pain 300mg Sustained Release Capsules: Each capsule contains 300mg ibuprofen Indications. For the relief of backache, rheumatic pain and muscular pains. Dosage and Administration: For oral administration and short term use only Adults, the elderly and children over 12 years: Take 1 or 2 capsules with water, twice daily. Do not suck or chew capsules. Leave at least 8 hours between doses. Do not take more than 4 capsules in any 24 hour period Not for use by children under 12 years of age. Contraindications. Hypersensitivity to ibuprofen or other constituent. History of hypersensitivity reactions (e.g. asthma, rhinitis, angioedema, or urticaria) in response to aspirin or other non-steroidal anti-inflammatory drugs. History of, or existing gastrointestinal ulceration/perforation or bleeding. Severe hepatic failure, severe renal failure or severe heart failure. In last trimester of pregnancy there is risk of premature closure of the foetal ductus arteriosus. Onset of labour may be delayed and the duration increased with increased bleeding tendency in both mother and child. Precautions and Warnings: Caution in patients with certain conditions, which may be made worse, e.g.: systemic lupus erythematosus and mixed connective tissue disease, gastrointestinal disorders and chronic inflammatory intestinal disease, hypertension and/or cardiac impairment, renal impairment, hepatic dysfunction. The elderly are at increased risk of the consequence of adverse reactions. Bronchospasm may be precipitated in patients with bronchial asthma or allergic disease. Do not use with other NSAIDs, including COX-2 specific inhibitors. Female fertility may be impaired by a reversible effect on ovulation. GI bleeding, ulceration or perforation. Caution is required in patients on medications which increase the risk of gastrotoxicity or bleeding If GI bleeding or ulceration occurs, stop treatment and refer to a doctor. If mucosal lesion, skin rash or other sign of hypersensitivity occurs, the treatment must be stopped. Side Effects. Hypersensitivity reactions may include non-specific allergic reactions, anaphylaxis, respiratory tract reactivity (e.g. asthma, bronchospasm) and various skin reactions (e.g. pruritus, urticaria, angioedema). For a full list of potential adverse events, see the Summary of Product Characteristics. Adverse events should be reported . Reporting forms and information can be found at www.yellowcardgov.uk Adverse events should also be reported to Reckitt Benckiser Healthcare Uk Ltd 0500 455 456. MRRP (Excl. VAT): £2.68 (12 capsules) £4 97 (24 capsules) Legal Category: P. Product Licence Number. PL 000327/0101 Licence Holder: Crookes Healthcare Limited, Nottingham NG2 3AA. Date of Revision July 2010 Ref: N-UK-164-10

Have your say on C+D's news. Email us at:
haveyoursay@chemistanddruggist.co.uk

Group Editor
Gary Paragpuri MRPharmS
020 7921 8045
Deputy & Features Editor
Jennifer Richardson 020 7921 8084
News Editor
Zoe Smeaton 020 7921 8141
Digital Content Editor
Niall Hunt 020 7921 8185
Clinical & CPD Editor
Chris Chapman 020 7921 8086
Reporter
Hannah Flynn 020 7921 8194
Production Editor
Harriet Kinloch 020 7921 8249
Senior Sub Editor
Brooke Balza 020 7921 8236
Group Art Editor
Richard Coombs 020 7921 8240
Designers
David Farram 020 7921 8198
Jo Konopelko 020 7921 8196
Office Manager
Elaine Steele 020 7921 8110
(fax): 020 7921 8132
elaine.steele@ubm.com
Interim Sales Director
Deborah Heard 020 7921 8119
Advertisement Manager
Daniel Spruytenburg 020 7921 8126
Field Sales Manager.
Andrew Walker 020 7921 8123
Online Support Operative
Jonathan Franklin 020 7921 8333
Classified Sales Executive
Dan Linton 020 7921 8456
C+D Data
Mark Johnson (Director)
07786 703638
Devi Patel (Operations Manager)
020 7921 8235
Michael Pavey (Business Development Manager) 020 7921 8422
Colin Simpson (Price List Controller)
020 7921 8667
Darren Larkin (Electronic Data Controller) 020 7921 8294
Mira Inameti (Data Specialist)
020 7921 8115
Sandra Drawbridge (Input Clerk)
020 7921 8674
Projects Director
Patrick Grice MRPharmS
020 7921 8335
Training Development Managers
Sara Mudhar MRPharmS
020 7921 8414
Kinna McConochie MRPharmS
020 7921 8413
Training Sales Manager
Paul Thorp 020 7921 8426
Projects Administrator
Pauline Sanderson 020 7921 8425
Projects Admin Assistant
Lewis Swan 020 7921 8420
Production Controller
Christine Langford 020 7560 4133
CEO, UBM Medica UK
Phil Callow 020 7921 8405
Email
firstname.surname
@ubm.com

"WITH ONLY A SHORT WHILE UNTIL GPs TAKE OVER THE COMMISSIONING REINS, THE PRESSURE IS ON FOR PHARMACY TO BUILD AN EVIDENCE BASE FOR ITS FUTURE SUCCESS"

With the Treasury's constant focus on cutting costs, you'd be forgiven for thinking the government had developed a form of obsessive compulsive disorder. It's inescapable. There isn't a day that doesn't bring dire warnings of budget cuts, redundancies and a demand that the public sector delivers more for less.

For pharmacy – which has in recent years faced more than its fair share of financial clawbacks – the future doesn't look pretty. Generally regarded as the poor cousin to GPs, there are numerous examples of community pharmacy services that show promise only to end up on the scrap heap when the funding is pulled from under them.

And so the news this week should be no surprise: Northern Ireland's community pharmacy-led minor ailments service (MAS) is being curtailed (p5). From next month, pharmacists can no longer treat coughs, colds, sore throats, nasal symptoms and allergic rhinitis under the service.

While these conditions aren't exactly life-threatening, a significant number of patients still felt unwell enough to consult a healthcare professional.

These patients aren't going to suddenly start self-medicating – in fact I'd wager that GPs will find themselves facing a surge in unnecessary workload from next month (with the NHS indirectly picking up the tab).

Yet the emerging evidence is increasingly demonstrating just how effective the UK's 12,000-strong pharmacy network can be at delivering more for less (or even more for the same). A great example is the healthy living pharmacy (HLP) initiative in Portsmouth, which has just released its interim findings (p4). A 100 per cent increase in people quitting smoking compared to those in non HLPs, more effective results during a PCT alcohol intervention campaign, a greater number of targeted MURs and 28 health trainer champions trained to maximise health promotion campaigns.

Yes, these are early figures and there is clearly more to come, but the data is encouraging and starts to turn pharmacy's perceived value into the kind of statistics commissioners will find hard to ignore.

With only a short while until GPs take over the commissioning reins, the pressure is on for pharmacy to build an evidence base for its future success. Portsmouth's HLP scheme may provide validated results but the sector needs to muster more.

At this week's APPG meeting (p4), it was suggested there is a mountain of evidence from previous pharmacy enhanced services sitting in PCT cupboards up and down the country and there is only a short window of opportunity to collect it.

It's likely to be a Herculean task, but if anyone wants to work with C+D in trying to obtain that information, get in touch at haveyoursay@chemistanddruggist.co.uk.

Gary Paragpuri, Editor

Sector must ride the new NHS wave says Baroness Cumberlege

APPG hears sector must embrace NHS reforms and gather systematic evidence for services

Zoe Smeaton
zoe.smeaton@ubm.com

If community pharmacy is going to flourish in the reformed NHS it needs to gather systematic evidence that it can deliver benefits, and it must work within the new NHS structure rather than fighting against it, experts have said.

Baroness Cumberlege, vice-chair of the all-party pharmacy group (APPG), said: "I think it's very comforting to think that we don't want competition, we want a centralised system and we want a part in the [GP] consortia, [but] that isn't the agenda, that really isn't." She continued: "We've got to ride the wave [with this agenda] otherwise we'll be stuck and taken apart and I think that would be a tremendous pity."

Baroness Cumberlege advised pharmacists to work together once the planned commissioning bodies, GP consortia, had been formed to show commissioners what they could offer. But others at the APPG meeting this Monday warned pharmacy needed to act quickly to gather the systematic evidence to present to GP consortia as evidence for services.

Baroness Cumberlege: work together to show commissioners what you can offer

Gary Warner, of Regent Pharmacy on the Isle of Wight, said: "I wonder how much of that evidence is locked away in PCTs' filing cabinets? The problem is that in a year or two that will disappear."

Kevin McGee, chief executive at Heart of Birmingham PCT, warned: "There is a real danger that you can point to examples but there isn't that systematic [approach] to the evidence base." He said the sector needed to work together in the next two years to pull such an evidence base together to support continuing enhanced services in the future.

Evidence 'aplenty'

If the government wants evidence that pharmacy provides value for money, there is plenty that pharmacy contractors can point to in support of their case, according to chair of the Association of Independent Multiple Pharmacies (AIMp) Peter Cattee.

"Exhibit A might be the 17 per cent increase in script numbers that pharmacists have absorbed between 2005 and 2008," he told the association dinner on October 20. He added: "Exhibit B could be the 1.5 million MURs performed annually and absorbed into this increasing dispensary workload. Exhibit C is the 27,000 enhanced services provided by community pharmacy in 2008-09."

Mr Cattee said community pharmacy was lacking direction and support to deliver, rather than evidence. **PG**

Healthy living pharmacies are 'a success'

The Portsmouth healthy living pharmacy initiative has delivered encouraging results and a successful alcohol awareness campaign in pharmacies has led to a new enhanced service in the region.

The healthy living pharmacy scheme was introduced in December 2009.

An interim report showed in the first five months of 2010, the number of people quitting smoking in Portsmouth was more than double the figure for the same period in 2009.

The report was released at the APPG meeting on Monday and said, in 2010, 333 people quit smoking in Portsmouth.

The average number of quitters for a healthy living pharmacy was 25.1 per month.

People interested in smoking cessation who visited an accredited healthy living pharmacy were twice as likely to quit as those visiting a non-accredited community pharmacy.

Portsmouth pharmacies also successfully provided an alcohol awareness campaign in June 2010, making nearly 2,000 interventions.

NHS Portsmouth's director of public health and primary care Dr Paul Edmondson-Jones told the APPG this meant around 200 people may have been helped, as Nice evidence suggests when interventions are made one in 10 people will end up changing their behaviour.

The effectiveness of the campaign has led the PCT to commission an enhanced service from pharmacy beginning this month. **ZS**

APPG meeting in brief...

"[The] any willing provider [model] works providing... pharmacists get the confidence to know that there is an ability for them to provide services."
Sue Sharpe, chief executive, PSNC

APPG meeting in brief...

"There's a very short time window in which everybody in the system needs to work together to collect the information to provide the evidence base [for pharmacy services]."
Kevin McGee, chief executive, Heart of Birmingham PCT

APPG meeting in brief...

"Reports have said [pharmacy] needs a QOF that aligns with GP commissioning so we're supporting each other in trying to achieve health outcomes."
Graham Phillips (left), Manor Pharmacy, (Wheathampstead) Ltd

"I think if we just say we hate your policies, and you're very free to say that and feel it, but you won't get anywhere."
Baroness Cumberlege vice-chair, APPG

Minor ailments cuts in Northern Ireland branded short sighted

Health department is urged to reconsider decision to slash list of eligible conditions

Miriam Reissner

Sector leaders have expressed dismay at a decision to restrict the community pharmacy minor ailments service in Northern Ireland, calling the decision "short sighted" and warning patients will suffer.

From November 1, the service will be revised, with patients suffering coughs, colds, sore throats, nasal symptoms and allergic rhinitis no longer eligible for the scheme, the Department of Health, Social Services and Public Safety has announced.

In the current service, launched in January 2009, pharmacists can treat these and other conditions, saving patients from visiting their GPs.

But, in a letter to contractors, Northern Ireland's Health and Social Care Board said an evaluation of the service had showed most people used it for self-limiting illnesses. "Given the current trend in expenditure, urgent action is required to ensure that the scheme remains within budget," it says.

And it said the service would no longer include the management of ailments that require only symptomatic relief.

Revisions to the minor ailments service will disadvantage pharmacy and patients

Gerard Greene, chief executive of the Pharmaceutical Contractors' Committee, said he was "disappointed and dismayed" at the plans.

He warned GP consultations could cost between four and five times more than pharmacist consultations and urged the department to reconsider.

Owner of Belfast's Maguire Pharmacy Terry Maguire said the decision was "hugely disappointing". "The department is saying that the cost-supply is not effective, but that is extremely short-sighted. The aim was to steer away from GP practices where GP services are so cluttered up," he added.

Expert reaction

"We believe that cutting the minor ailments service will inadvertently cost the public purse, as GPs will become inundated with patients who until now could have accessed advice and NHS treatment for these conditions at their community pharmacy."
Gerard Greene, chief executive, PCC

"Overall it's bad news. We have some PCTs in England that have started to do the same thing and pull back."
Alastair Buxton, head of NHS services, PSNC

"It's a step back for all the work that's been done and it fails to recognise the service of community pharmacy."
Terry Maguire, Maguire Pharmacy, Belfast

Sector engaging with GP commissioning

Pharmacy groups are already starting to engage with doctors hoping to take part in government programmes to fast-track the development of some GP consortia, C+D understands.

The government "pathfinder programme" will enable pioneering GPs to test design concepts for the consortia, which will be responsible for commissioning services.

Liz Stafford, commissioning lead for Rowlands Pharmacy, told C+D: "Rowlands Pharmacy is already actively engaging with pathfinder sites. We see it as a key priority for our business."

The programme will be designed to ensure that any issues with GP commissioning can be identified and shared, according to the DH.

Georgina Craig, NHS Alliance pharmacy commissioning network lead, said the pathfinder sites were key. She added: "It's essential that a number [of sites] explore how GP commissioning and pharmacy commissioning best dovetail."

Ms Stafford, who is also the pharmacist member of the NHS Alliance GP commissioning federation executive, said commissioning packs being given to pathfinder GPs should be made available to pharmacists.

"This will ensure providers and commissioners have constructive discussions from the start," she explained.

Pharmacy bodies said they were working together to identify clinical leaders in community pharmacy who could work and engage with GP consortia. **HF**

APPG meeting in brief...

The APPG meeting in figures

15% chlamydia screening rate in City and Hackney now pharmacy offers the service

2,000 seasonal flu vaccinations done in Isle of Wight pharmacies this year

62% quit rate for smokers in Portsmouth healthy living pharmacies

3,649 patients took part in Portsmouth alcohol interventions in June 2010

APPG meeting in brief...

Evidence exists

The DH's community pharmacy tsar Jonathan Mason told the APPG meeting that evidence for pharmacy services "is there". He pointed to chlamydia screening in his own PCT, City and Hackney, where screening rates have jumped from 1 per cent to 15 per cent since a community pharmacy scheme started. "Pharmacy is really delivering on chlamydia screening," he said.

APPG meeting in brief...

Dispensary talk

What do you make of your PCT's pharmaceutical needs assessment?

"They need to have a look at what the community requires. It's a very hard job trying to meet expectations for financial reasons, and because people become used to the NHS being able to solve all their problems."
Nicola Passmore, Manor Pharmacy, Newark

"If I could translate it into English I would understand it."
Cath Boury, Newland Community Pharmacy, Hull

Web verdict

Great – accurate and presents lots of opportunities
9%

Looks about average
17%

Below average – we spotted a few errors
9%

Poor – it's a mish mash of information
65%

Armchair view: PCT's aren't getting pharmacists' votes with their pharmaceutical needs assessments, with most C+D readers branding the documents a mess and less than one in 10 giving them a real thumbs up.
Next week's question:
Will pharmacy be able to 'ride the wave' of Andrew Lansley's NHS reforms? Vote at
www.chemistanddruggist.co.uk

GPhC consultation on CPD non-compliance

Remedial measures touted as alternative to removal from register

Hannah Flynn
hannah.flynn@ubm.com

The GPhC is set to consult on plans to allow the registrar to impose remedial measures on pharmacists not complying with CPD requirements, rather than removing them from the register.

The consultation on the CPD framework and rules will launch in November, alongside one on educational standards.

GPhC chief executive Duncan Rudkin told C+D pharmacists should understand removing people from the register over failure to comply with CPD would be a "last resort".

He added that pharmacists who had had their records recalled already had reported being quite pleased with the results so far, although they admitted initially being nervous.

The GPhC said following comments from Council members, the structure of the draft CPD rules had been changed to make clear that the registrar can impose remedial measures rather than removing pharmacists from the register if they do not meet the required CPD standards. This had been done to ensure that safeguards were in place for pharmacists who fail to comply with CPD standards, but would allow for flexibility.

Mr Rudkin told C+D the move separated complying with CPD standards from other issues, as CPD failures may not affect fitness to practise.

Boots: don't be put off career in pharmacy

Boots has urged students not to be put off a career in pharmacy by the government's proposed hike in tuition fees.

Pradip Patel, the multiple's HR, stores and professional development director, said pharmacy offered a variety of work with good reward levels. He added students should "take a long term view" of their careers and so not be deterred.

The comments followed the British Pharmaceutical Students' Association warning that plans to raise tuition fees could put students off applying to take longer courses such as pharmacy (C+D, October 23, p8).

Mr Patel said the impact of tuition fee rises would become evident in the next few years but added that he hoped students would continue to recognise the value of a pharmacy career. **CC**

Clinical debate — C+D's Chris Chapman looks at the evidence behind the headlines

The drug misuse conundrum

Opioid replacement therapy (ORT), most commonly with methadone, is one pharmacy service that is constantly under threat. The reason is obvious: the patients are drug misusers, and so are often vilified as symptomatic of societal problems.

An example is Project Prevention, a US group arriving in the UK that offers drug misusers cash incentives to use birth control or to get sterilised. I'm not even going to give that idea publicity.

This week battle lines were drawn up yet again, with a paper in the BMJ possibly tangling up the government in conflicting policies.

The government view on methadone is not a positive one. In April, Prime Minister David Cameron said opioid substitution therapy "does not deal with the problem" of drug misuse, stating "we must be mad as a country not to get people into that residential rehab".

During the election I spoke to now-health secretary Andrew Lansley, who echoed Mr Cameron's words. But a paper this week has come out in favour of longer term ORT in a big way. Using the UK General Practice Research Database, the BMJ study looked at 5,577 patients with 267,003 prescriptions for ORT, following them until one year after the expiry of their last prescription – a total of 17,732 years.

The study found that mortality rates for patients on ORT were around half those for patients not on the therapy – the crude mortality rates were 0.7 per 100 person-years and 1.3 per 100 person-years. respectively. There were peaks in mortality in the first weeks starting treatment, and in the first weeks of withdrawing treatment. Overall, ORT was found to have more than an 85 per cent chance of reducing mortality if patients remain on treatment for more than a year.

For pharmacists, there is an important message: extra vigilance is needed when treating patients who are starting, or finishing, ORT.

The paper creates a conundrum for a government that has previously set out its stall in favour of residential rehabilitation (despite the cost). In its white paper consultation on outcomes, the Department of Health states a core principle as: "People should not die early where medical intervention could make a difference." Opioid replacement therapy has shown it fits the bill.

Chat with Chris on Twitter:
www.twitter.com/CandDChris

Winthrop
PHARMACEUTICALS
Economise without compromise

For further information please freephone 0800 854431 or contact Winthrop Pharmaceuticals, 1 Onslow Street, Guildford, Surrey GU1 4YS. Fax number 01483 554809.
GB.SAA.10.07.01 Date of preparation: June 2010

See videos of C+D Senate Live at
www.chemistanddruggist.co.uk

Boots to the rescue

A Boots pharmacy was called on to provide emergency medication for patients in a care home, after a fire destroyed the building at Culloden Court in Smithton, Inverness. Pharmacist Jennifer Stephen, who works at the Smithton branch of Boots, said the pharmacy replaced all medication destroyed in the fire.

Nice and NPC to merge

The National Prescribing Centre (NPC) is to merge with Nice in response to health secretary Andrew Lansley's health white paper. Department of Health ministers have approved the planned merger, with the change due from April 2011.

Price List VAT change

The retail prices listed in the C+D Monthly Price List and on the online database will be changed to reflect the new rate of 20 per cent on January 4, 2011. The January Price List will show VAT at 17.5 per cent, but will contain a ready reckoner calculated at 20 per cent. **www.cddata.co.uk**

Medicines management

Change is urgently needed in the NHS to improve "unacceptable levels of patient harm" in Wales caused by a lack of medicines education, the Royal Pharmaceutical Society has said.

Three-year rule

A petition against the UK's rule preventing EU pharmacists being the responsible pharmacists in pharmacies registered less than three years will be heard at the EU parliament in Brussels on November 9.

Scotland control of entry

The Scottish government has published a review of responses to the control of entry consultation for pharmacy in Scotland. Director of the RPS in Scotland Alex MacKinnon said the new plans would help ensure that patients in rural areas have access to full pharmacy services.

NPA names Mike Holden as new chief executive

Hampshire & Isle of Wight chief officer set to take association helm

Jennifer Richardson/Zoe Smeaton
jennifer.richardson@ubm.com

The NPA has appointed Mike Holden, currently chief officer of Hampshire & Isle of Wight LPC, as its chief executive.

Mr Holden, who has worked in community pharmacy for three decades, will take up the post – which was vacated by John Turk in April – in 2011.

The NPA said his "wealth of highly relevant experience and his clear commitment to helping the sector move forward places him in a great position to lead the NPA".

The appointment makes Mr Holden the third chief executive of the NPA in three years after Alison White left in January 2008 and Mr Turk this year (C+D, April 17, p4).

The association was unable to comment yet on what Mr Holden's first priorities would be in the position. But former chief executives John D'Arcy and John Turk said the key challenge was always to engage with members. "The strength of the NPA is its members so it will only be as effective as its relationships with them," Mr D'Arcy said.

Mike Holden: to take NPA helm in 2011

He added that with a relatively new chief executive at the professional leadership body too it would be interesting to see how the two representative bodies ended up playing their different roles.

Mr Holden sits on the National Public Health Leadership Forum for Pharmacy and helped develop the government-backed Healthy Living Pharmacy initiative in Portsmouth (see p4).

He said: "There could not be a more critical time to be chief executive of the NPA, leading community pharmacy through the transformational change that will undoubtedly take place in the NHS over the next few years."

English free script plan halted

Plans by the former Labour government to extend free prescriptions to all patients with long-term conditions in England have been scrapped as part of the latest Department of Health (DH) spending review.

The move follows the announcement that prescription fees will be abolished in Scotland next year (C+D, October 23, p7).

Experts said although the decision to keep the charges in England would have no financial impact on pharmacies, it could raise patient concerns about the system.

Alastair Buxton, head of NHS services at PSNC, said: "I think with patients in Wales and soon, Scotland, enjoying free prescriptions, it could raise a kind of 'West Lothian question'."

He added that the only change that free prescriptions would bring would be the removal of a layer of bureaucracy for pharmacists.

His views were echoed by community pharmacist Michael Maguire, who also called for a review of the whole English system.

Mr Maguire, of Marton Pharmacy in Middlesbrough, said: "It does seem strange that in Wales and Scotland people will be able to get prescriptions for free, whereas in England there are some long-term conditions that are covered and some that aren't."

A spokesperson from the DH said the exact terms of the original plans to remove the charges in England had never been set out and added that the "status quo" for prescriptions would not change for patients and pharmacists. **HF**

C+D Senate calls for new funding model

Pharmacy must grasp the opportunities presented in the government's health white paper or risk losing out on funding, the C+D Senate has warned.

Speaking at the Senate Live at the C+D Conference, NPA chairman Ian Facer said the industry must make a decision on how it wanted to be funded in the future.

PSNC chief executive Sue Sharpe said she thought the government needed to be shown what pharmacy could contribute to primary healthcare as a matter of urgency.

She said: "That white paper, which sets out its very general policies, means that now is absolutely the right time for pharmacy to be saying what we can provide."

Mrs Sharpe added that changes to the services and remuneration model needed to be made in the next three to four years, after taking into account the time needed to retrain and upskill pharmacy staff.

"Pharmacy needs to be in a position of having these services related to medicines, and health and wellbeing services, well bedded in. And I think we need to be making our pitch to do that in the next six months," she said. **HF**

Read coverage of the C+D Senate Live
See page 22

We're sending you more customers

Now get the training you need to help them

In September, the high-impact consumer campaign for Flomax Relief® MR will return and drive men into your pharmacy.

They'll be expecting you to be specially trained to help them get proven relief from the first ever non-prescription BPH treatment. Men tend to behave in a reactionary way to healthcare services,[1] so you need to be ready to take this opportunity to engage with them and provide the right support.

Register at **www.flomaxrelief.co.uk/hcp** or call **0845 338 9968** to **access the full range of training materials** on BPH and Flomax Relief. You'll soon be able to give your customers all the help they need, and it could contribute towards your CPD.

Follow pharmacy tsar Jonathon Mason's tweets at **www.chemistanddruggist.co.uk/mason**

The knock-on effect of knock-off medicines on the internet

With spam from rogue pharmacies hitting our inboxes every day, **Chris Chapman** asks how the sector can protect patients while harnessing the potential for legitimate online growth

The one certainty about owning an email account is that, at some point, you'll be sent an email promising drugs to enlarge your penis – whether or not you have one.

Last month internet giant Google launched charges against online rogue pharmacies, probably sending emails like these, slamming them as bad for "our users, for legitimate online pharmacies and for the entire e-commerce industry". And earlier this month the MHRA and UK Border Agency seized £570,000 worth of illicit medicines as part of a global crackdown, raiding premises linked to 12 websites.

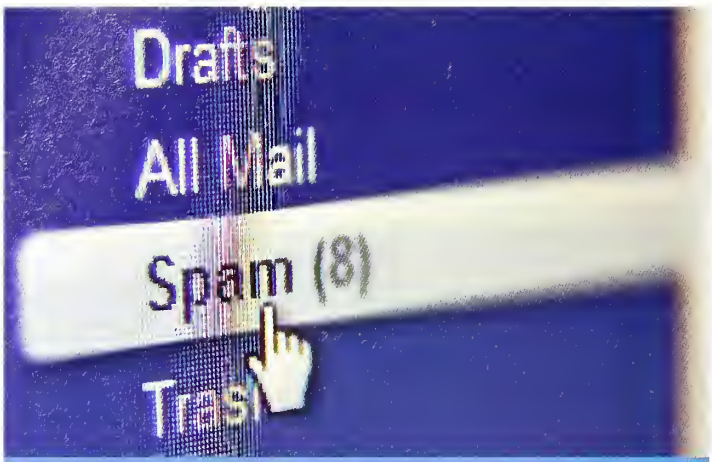
The problem isn't going away, with police currently trying to close down a further 183 websites in the UK. But what does this thriving cyber trade in knock-off medicines mean for community pharmacy, and how can patients know who to trust on the internet?

Online pharmacy is a popular area of expansion for pharmacy retailers, with multiples such as Boots, Lloyds, Rowlands and Asda offering medicines safely and legally. The internet is an area with big potential, and it could provide patients with a convenient new way to access their medicines and deliver care to patients who are housebound or unable to access a pharmacy.

But where there is potential for legal profit, there is also potential for illegal profit and for crime. And Pfizer estimates the value of the European illicit drugs market is around £9 billion.

The problem seems to be a lack of knowledge, says Pfizer medical director David Gillen. Around a quarter of patients in a survey the company conducted in 2009 didn't consider taking medicines without a prescription to be risky. Dr Gillen says there is a "clear need" for greater public awareness and education. "People are not only unaware of the very real dangers of counterfeit medicines, but also that they're fuelling an illegal and harmful drug market," he said.

This lack of education puts patients at risk, exposing them to medicines with no quality control. And it's bad for the sector, as the counterfeiters are also undermining public trust in pharmacy, creating a bad name for sites that provide appropriate, quality-assured healthcare.



Is an internet pharmacy legitimate?

The GPhC recommends patients take the following steps to check the credentials of an internet pharmacy:

1. Locate the name and address of the pharmacy operating the site
2. Check the pharmacist and pharmacy are registered
3. Avoid websites that offer POMs without a prescription
4. Check you are asked questions before purchasing the medicine

"It's bad, because this tarnishes all online pharmacy," says Mitesh Soma, founder of online pharmacy Chemist Direct. "We do show we're reputable with the green cross [linked to the regulator's register], our telephone number, and a whole section to show we're a real business. All of these things help to reinforce [the fact that] there are legitimate businesses out there."

The General Pharmaceutical Council (GPhC) acknowledges there is "a great deal of confusion" about the regulation of internet pharmacies among the general public. In 2008, the RPSGB took steps to rectify the situation, introducing a non-mandatory logo for sites. However, a recent report by the Nuffield Council on Bioethics said patients were not sufficiently aware of this (C+D, October 16, p6). And the GPhC recommends patients should take additional steps to confirm the source of their medicines (see panel above).

But even where patients can distinguish between real and bogus sites, human factors come into play, too. According to the MHRA, the types of drugs counterfeiters thrive on are predominantly lifestyle drugs, such as those for erectile dysfunction and weight loss, or drugs open to abuse, such as pain relief and antidepressants.

"With prescription-only medicines, there are a lot of people who don't want to get a prescription, because they are embarrassed," says Kimberley Estenson, of online pharmacy Express Chemist. While this embarrassment exists, it's going to create a hurdle to purchases and keep people going online. And it also creates a tightrope that pharmacists supplying online must walk.

For example, in May, Boots and Lloydspharmacy faced criticism from the BBC's Watchdog, which showed an underage customer purchasing Alli at Boots' online store, and an anorexic customer buying the drug online at Boots and Lloydspharmacy after lying about her BMI. But as Boots points out: "We cannot let the actions of a few individuals prevent the vast majority of customers who need and are entitled to purchase these products from accessing them."

Pharmacists have a responsibility to put restrictions on purchases, and ask questions to ensure medicines are appropriate. However, the key advantage of online pharmacy is that it is accessible, so making access too difficult can drive consumers to unregulated sites, with no guarantees of the quality, safety or appropriateness of medicines. Checks must be carried out where needed, but not at the expense of making online purchases too restrictive.

The threat of counterfeit medicines and bogus pharmacies isn't going anywhere – the trade is too lucrative – so trying to end counterfeit medicines online is a tough ask. Instead, perhaps pharmacy needs to use the hard-won relationships it has formed with patients to make sure they understand which sites are safe to use.

Making sure patients embrace the GPhC logo, in the same way that the Kitemark has become a recognised safety standard, could make a huge difference. Only then will pharmacy be able to capitalise on the potential of online pharmacy, and also safeguard patients against dangerous counterfeit medicines.

The IT Zone

For all the latest news, views and more on pharmacy IT go to the IT Zone, supported by AAH, at **www.chemistanddruggist.co.uk/ITzone**

the IT ZONE

Supported by AAH

NO.1 SELLING* FOR YEARS

and the reasons couldn't be clearer

Otex Ear Drops

The best-selling* pharmacy only ear drops

Otex Express Combi Pack

A complete kit to treat ear wax at home

Otex Express

Self-selection ear drops

- Clinically proven to reduce the need for syringing
- Driving sales - on TV throughout the year!
- The UK's best-selling* ear wax treatment, Otex!

www.otexear.com

Otex
Be clear to hear

OTEX Product Licence, Trademark and medical device registrations held by Diomed Developments Ltd., Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd., 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. **Indications: Otex Ear Drops** and **Otex Express Ear Drops:** An aid in the removal of hardened ear wax. **Combi Pack:** Complete ear wax removal kit comprising Otex Express Ear Drops to initially soften and disperse wax, and a bulb syringe to then gently cleanse the ear. **Directions** (for adults, the elderly and children over 12 years old): **Otex Ear Drops** and **Otex Express Ear Drops**: Instil up to 5 drops into the ear. Repeat once or twice daily for at least 3 to 4 days, or as required. **Combi Pack:** After using the ear drops for 3 to 4 days, cleanse the ear by filling bulb syringe with warm water, positioning the nozzle of the bulb into the opening of the ear canal and gently squeezing the bulb, allowing rinse water to run out of the ear into a basin. **Contraindications:** Do not use if the eardrum is known or suspected to be damaged, in cases of dizziness, or if there is, or has been, any other ear disorder. Do not use after ill-advised attempts to dislodge wax using fingernails, cotton buds or similar implements, or within 2 to 3 days of syringing. Do not use where there is a history of ear problems, unless under close medical supervision. Do not use if sensitive to any of the ingredients or at the same time as anything else in the ear. **Precautions:** Keep away from the eyes. For external use only. Replace ear drops cap after use, and return bottle to carton. Do not push the nozzle of the bulb syringe deep into the ear canal or allow the nozzle to block the flow of water leaving the ear. Do not use syringe to instil drops. **Side-effects:** A mild, temporary bubbling sensation in the ear can occur when using the drops. Use of ear drops or irrigation with the bulb syringe can aggravate the painful symptoms of excessive ear wax, including some loss of hearing, dizziness and tinnitus. Very rarely, unpleasant taste has been reported when using the drops. **Packs and Legal Category:** Otex Ear Drops 8ml [P], RSP £4.65 (£3.96 ex. vat) PL 0173/0151, Otex Express Ear Drops 10ml RSP £4.95 (£4.21 ex. vat), Otex Express Combi Pack comprises 10ml of ear drops and a soft bulb syringe. RSP: £7.95 (£6.77 ex. vat) *Source: IMS MAT volume and value sales.

NiQuitin Minis get new fruity addition

GSK Consumer Healthcare has added cherry-flavoured lozenges to its NiQuitin Minis range.

The 1.5mg Minis come in packs of 20 or 60 and are available in a pocket-sized container, making them easy to use on the go, according to the company. They can be used alone or in combination with patches to tackle breakthrough cravings, a spokesperson says.

Prices: £4.99/20; £13.99/60
Pip codes: 356-8888; 356-8896
GSK Consumer Healthcare
Tel: 0845 762 6637
www.mypharmassist.co.uk

Market focus

- The smoking cessation market is worth £102.8m.
- Pharmacy has a 55 per cent market share, worth £57m.

Source: SymphonyIRI Group, 52 weeks to December 26 2009

RetarDEX freshens up packs

Oral hygiene specialist Periproducts has announced its RetarDEX range is set to be repackaged with a "cleaner, more modern look".

The range, which includes oral rinse, toothpaste and spray, will appear on shelves in its new packaging from next month.

The relaunch marks the second phase of the company's growth strategy to increase its 14 per cent share of the medicated mouthwash market, according to a spokesperson.

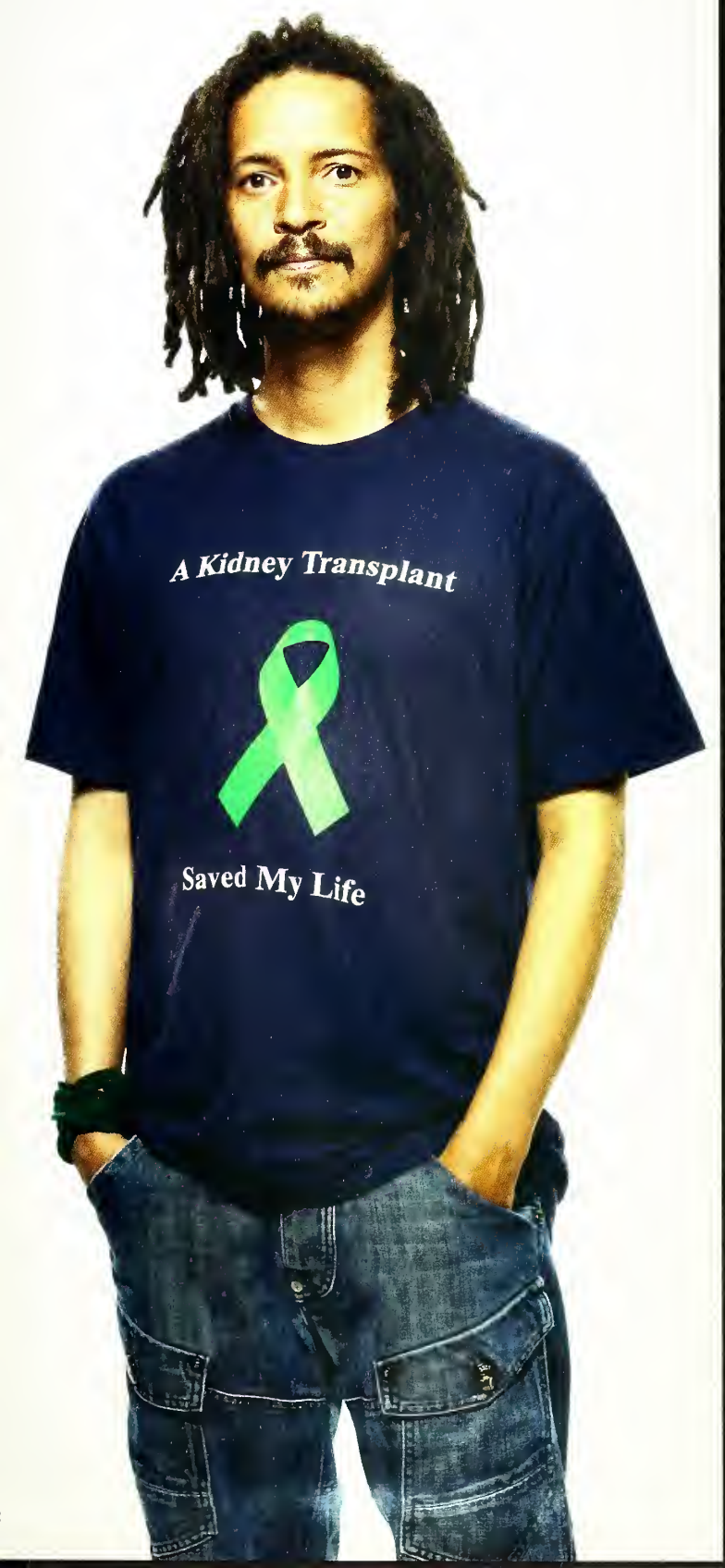
A television campaign over the summer saw brand awareness nearly double, says Periproducts managing director Richard Bernholt.

Prices and Pip codes: See C+D Monthly Price List or www.cddata.co.uk
Periproducts
Tel: 020 8868 1500

Multibionta range gets a boost

Seven Seas, has announced an addition to the Multibionta range to attract impulse buyers. The launch of Multibionta Boost, an orange-tasting effervescent drink, will be backed by an "intensive" PR and digital campaign, the company says.

Price: £4.29/12
Pip code: 355-8921
Seven Seas
Tel: 01482 716209



I was one of 7190 people waiting for a kidney*

5 years waiting†

12 hours of dialysis a week†

780 hospital visits†

1 car crash 3 families affected

2 ambulances 3 doctors 4 nurses

1 specialist transplant team

1 organ donor 1 life-changing gift

1 personalised drug regimen

Now it's up to you

Tacrolimus. Be specific.

Always use the brand name

Prograf® tacrolimus

ADVAGRAF® tacrolimus prolonged release

astellas
Leading Light for Life

Prescribing information can be found on the adjacent page.

Job code: PRG10028UK Date of preparation: June 2010

Boots Pharmaceuticals range for 'everyday' use

Boots has announced the launch of Boots Pharmaceuticals, a range of "everyday" healthcare products.

It will cover a variety of therapeutic areas with proven medicines and natural alternatives, according to the company.

The full range, including insect repellents and vitamins and minerals, will be rolled out over the coming months, according to a spokesperson.

The company has first introduced two sub-categories, Boots Pharmaceuticals Derma Care and Boots Pharmaceuticals Men's Sexual Wellbeing, now available in-store.

Boots Pharmaceuticals Derma Care offers a complete moisturising regime for dry skin sufferers, Boots says, with in-store advice from specially trained healthcare advisers who can provide support and advice on the management and maintenance of exceptionally dry skin conditions, such as eczema and dermatitis.

Boots Pharmaceuticals Men's Sexual Wellbeing range consists of five products, including those to tackle premature ejaculation and offer support for erectile function.

Bach online resource targets fans of natural healthcare

Bach Original Flower Remedies has launched a free online introduction course for people interested in its range. It has been designed to give those interested in natural healthcare a better understanding of the Bach system, including the popular Rescue Remedy, according to the company. The course can be accessed at www.bachintro.com.

Tixylix paediatric cough syrup addition meets NHS guide

Novartis Consumer Health has added Honey, Lemon and Glycerol Syrup to its Tixylix paediatric cough remedy range.

The syrup is the first branded paediatric product of its kind, according to the company, and can be used by children aged one year and over.

The addition follows the NHS recommendation that 'simple' cough mixtures containing glycerol, honey or lemon should be the first line of treatment for treating coughs in children over one year.

Price: £3.05/100 ml
Pip code: 356-8185
Novartis Consumer Health
Tel: 01403 218111

On TV next week

Covonia: All areas
Hedrin: GMTV, five, Sat
Otrivine: GMTV, five, Sat, C4
Seven Seas Cod Liver Oil: All areas
PharmaSite for next week: NHS Scotland and Welsh Assembly Government Flu Campaigns – windows, **NHS Scotland and Welsh Assembly Government Flu Campaigns** – in-store, **NHS Scotland and Welsh Assembly Government Flu Campaigns** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Xrayser

Patients don't know which way to turn

"UNDERSTANDING OF A HEALTHY DIET AND LIFESTYLE IS BEING BLURRED WITH MEDICAL TREATMENT"

A member of staff showed me a cutting from the paper this week with the headline, "Drinking alcohol could slash the risk of arthritis", and said: "That's rubbish – I drink regularly, and look at my arthritic hands!" Cheryl has recently started treatment, and her frustration was an example of how unhelpful such health reports can be.

It's impossible to open the paper without reading a health story. First there's the 'medical breakthrough story' which goes "Scientists find cure for Xrayser Syndrome! This research means treatment for Xrayser Syndrome could be available within five years..." But a week is a long time in the media, and any medical breakthrough promised "within five years" is unlikely to happen. Just as when I was at university and we thought that by 2010 we'd all be wearing silver foil and driving hover cars.

But then there's another type that is more insidious and harmful. All the media – both print and broadcast – are as irresponsible as each other, and Cheryl's cutting could have been any number of variations upon "Risk of disease increased by (insert name of commonly used drug such as calcium)", or "Risk of disease reduced by (insert name of commonly used drug or – more usually – food supplement such as aspirin, pine nuts, lark's tongues etc)". This is followed by patients discarding their "harmful" calcium & vit D, losartan, or atenolol, and the sound of tills ringing at the health food shops – and pharmacies. And no one counts the additional morbidity and mortality from the lost concordance, or misplaced mistrust of prescription medication.

Thinking about it, if we question the sale and promotion of homeopathic treatments, should we not also dissuade our patients from wasting money on any product promoted as having beneficial effect when there is no proof of beneficial outcome? There's a reason the NHS doesn't prescribe plant sterols in place of statins, oat bran for CHD, or probiotics for GI disorders. It seems that when it comes to getting your research in the news there has to be clever marketing. Always describe in vitro effects, and always insert the term "could" into your claims.

If it's hard enough for healthcare professionals to understand the nuances of clinical trials, how much more easily are patients persuaded of the benefit of 21st century snake oil?

Understanding of a healthy diet and lifestyle is being blurred with medical treatment and primary prevention.

We're currently taking part in the RPS lung cancer audit, to provide evidence that pharmacy increases public awareness of the disease. An equally important role for pharmacy is to guide patients through the mire of unbalanced claims in the media, and promotional marketing. There's too much of this bad science reporting, and maybe somehow tackling this could be the next RPS signposting audit.

Terry Maguire

The end of conference season?

Conference season has ended for another year and this year I attended only two. It could have been six; I'm sure some colleagues attended even more in that lazy space between the beginning of September and mid-October.

Conference should be a retreat, a time for reflection and self-refreshment, a space for revitalisation and personal development. Conference should be a marketplace where we view other's ideas, they view ours and we build alliances with the like-minded.

Perhaps it's my age, or a personal professional weariness, but I feel increasingly that I gain little from attending a conference. The talks and discussions seldom resonate with me as a pharmacist or businessman.

Is it me, or is the conference concept redundant? I really and sincerely hope it's me.

The British Pharmaceutical Conference (BPC) was to some degree experimental – not for me, but for the organisers. The challenge for the RPS, which organises the BPC, is to offer an exciting two- or three-day event attractive to pharmacists and other stakeholders that promotes a unity of purpose.

This is difficult, given that the factions created by the breakup of the RPSGB remain. BPC must clarify its USP. I want to leave sessions informed and inspired. I want debate and controversy that is open and honest.

As I strayed around central London to pass the evening I mourned the absence of any social focus at BPC. Where has the conference club gone?

BPC must be a showcase for practice research. Most schools of pharmacy now have practice research units and many are producing excellent work.

Sadly, too often this is communicated in an inaccessible and uninteresting way. Indeed I question why some research questions are asked at all – the results are utterly useless or simply a self-fulfilling prophesy. To cite an example of what I mean, I once attended a conference where I sat through a paper entitled Gay and Lesbian issues in smoking cessation.

When I asked the presenter why she asked this question in the first place, she provided a diatribe after which she agreed it was more politics than science.

This trend was even more prevalent at the other conference I attended, organised by the National Obesity Forum (NOF).

Those people the NOF held responsible for causing the nation's obesity problem 10 years ago are now at the table, satiating themselves on a banquet of comfortable compromise.

Yes, the BPC will require some revision to encourage me back.

Terry Maguire is a community pharmacist in Northern Ireland

"CONFERENCE SHOULD BE A RETREAT, A TIME FOR REFLECTION AND SELF-REFRESHMENT, A SPACE FOR REVITALISATION"

Update

Your weekly CPD revision guide

60-second summary

Why read this article?

Treatment for leukaemia can include a wide range of drugs with a variety of side effects. This module discusses when each treatment is considered, and how to manage possible side effects.

What treatments are used?

Treatment can include chemotherapy and radiotherapy, as well as bone marrow and stem cell transplantation or monoclonal antibodies. The choice of treatment depends on the type of leukaemia and the progression of the disease.

How can I manage side effects?

Many side effects can be managed by a few simple interventions. An effective prophylaxis strategy to prevent nausea and vomiting is vital as these can lead to non-compliance. Acute emesis can be managed by domperidone or metoclopramide, or a specific serotonin antagonist given with dexamethasone [illegible]. Lorazepam is used in patients who have anticipatory emesis because of its [illegible] sedative and anxiolytic effects.

Get Update emailed to you each week [illegible] at [illegible]druggist.co.uk/register

Leukaemia: part 2

The four types of leukaemia, their treatment options, and how to manage side effects

Helen Boreham MSci

Treatments for leukaemia range from conventional anticancer chemotherapy and radiotherapy to advanced biological drugs that target the disease's underlying molecular pathophysiology. Individual management decisions are complex and varied, guided principally by the type of leukaemia and key patient factors such as age and genetic profile. Main types of treatment for leukaemia include:

- chemotherapy
- radiotherapy
- transplantation – bone marrow or stem cell
- tyrosine kinase inhibitors
- monoclonal antibodies.

Treatment

1. Acute myeloid leukaemia (AML).
Chemotherapy is the main treatment approach for AML, divided into two phases – induction and consolidation. The goal of induction therapy is to achieve "morphological complete remission" – this involves normalisation of neutrophil and platelet counts and reduction in leukaemic blasts to <5 per cent of total white cell count in the bone marrow.[1] Patients with a favourable cytogenic profile generally receive two courses of induction, followed by one or two rounds of consolidation. AML sufferers designated 'intermediate' or 'poor risk' after profiling may be candidates for allogenic stem cell transplantation (SCT) if they respond to induction.[1] Consolidation is aimed at preventing the recurrence of leukaemia once remission has been achieved. It can consist of further chemotherapy, a donor transplant or – rarely in AML – an autologous stem cell transplant.[2]

Common cytotoxics used in AML chemotherapy include daunorubicin, cytarabine, etoposide, fludarabine, idarubicin, doxorubicin, thioguanine, amsacrine and mitoxantrone – at different doses and in various combinations. Most patients will have an induction regimen that starts with cytarabine and an anthracycline (any of the three rubicin drugs), with potentially a third agent added.[2]

First-line therapy of acute promyelocytic leukaemia (APML), an AML subtype with good prognosis, involves the retinoid all-transretinoic acid (ATRA; tretinoin). In combination with an anthracycline, this produces cure rates in excess of 80 per cent.[1] ATRA is not a cytotoxic but promotes maturation of malignant cells. Arsenic trioxide is the second-line treatment for APML and also gives high complete remission rates.

2. Chronic myeloid leukaemia (CML)
CML management has been revolutionised by the advent of the tyrosine kinase inhibitor (TKI) imatinib, which offers overall survival rate of 89 per cent after five years, and has now replaced the previous gold-standard therapy, cytarabine plus interferon alpha.[1] Nice recommends imatinib as first choice treatment for Philadelphia (Ph) chromosome carriers in the chronic phase of CML and as an option for patients presenting in the accelerated phase or with blast crisis, the terminal phase of CML, provided imatinib has not been used previously.[3]

Imatinib is generally preferred over allogenic SCT for the first-line therapy of newly-diagnosed chronic phase CML patients; however, SCT offers the only confirmed potential for a complete cure.[1] In patients eligible for SCT, rates of long-term remission or cure are approximately 60 per cent.[1]

For imatininb-resistant patients, the newer TKIs– dasatinib and nilotinib – are alternatives with greater potency, although nilotinib is not licensed for blast crisis.

3. Chronic lymphocytic leukaemia (CLL)
Currently, CLL is not curable. However, most patients with early-stage disease do not require treatment until the cancer progresses or symptoms become troublesome. Studies have shown immediate treatment offers no significant survival advantages but poses potentially serious side effect problems.[4] Instead, a policy of 'watchful waiting' is adopted, with regular blood tests and monitoring.

For patients in later disease stages of CLL (known as Binet stage two or three), treatment is recommended. Chemotherapy is the mainstay of CLL management and oral chlorambucil is the first-line agent of choice. Fludarabine, a purine analogue, is recommended by Nice as a second choice option for CLL patients who have failed or are intolerant of chlorambucil and would otherwise have received combination chemotherapy.[5] Typical chemotherapy combinations used in CLL include:

- CHOP – cyclophosphamide, doxorubicin, vincristine and prednisolone
- CAP – cyclophosphamide, doxorubicin and prednisolone
- CVP – cyclophosphamide, vincristine and prednisolone.

Newer monoclonal antibody therapies for CLL include alemtuzumab and rituximab. Rituximab is a chimeric antibody that binds selectively to the CD20 antigen expressed on the surface of mature B-lymphocytes and tumour cells. It is recommended by Nice – in combination ▶▶

Meet the new Olbas family!

- All new, fresh, modern packaging across the range
- ON TV – a brand new family of the famous Olbas noses

So stock up with the whole family of Olbas products now!

Call 01452 507 458

www.olbas.co.uk

with fludarabine and cyclophosphamide – as a first-line option for CLL in patients suitable for fludarabine and cyclophosphamide combination therapy.[6]

Like rituximab, alemtuzumab also causes lysis of B lymphocytes and is licensed for CLL where fludarabine treatment is not appropriate.[7] Nice has not yet reviewed alemtuzumab but the Scottish Medicines Consortium has accepted it for restricted use in previously untreated B-cell CLL patients with the cytogenetic abnormality 17p-deletion.[7]

4. Acute lymphoblastic leukaemia (ALL)

Chemotherapy is the main treatment for ALL and 80 per cent of patients will achieve remission. Treatment for ALL follows three phases:[7]

- Induction – an initial intensive phase of treatment to destroy leukaemic cells. Common chemotherapy drugs used are vincristine, daunorubicin or doxorubicin, methotrexate, crisantaspase (asparaginase), mercaptopurine and cyclophosphamide.
- Intensification (consolidation) – further chemotherapy to destroy residual leukemic cells in the blood or bone marrow. Drugs include cytarabine, etoposide and tioguanine (thioguanine).
- Maintenance – to reduce the risk of recurrence. Usually oral mercaptopurine or methotrexate, or intravenous vincristine.

Some ALL patients will be suitable for high-dose treatment (including total body irradiation and high doses of etoposide or busulfan) followed by stem cell transplant. Carriers of the Ph chromosome may receive imatinib.

Cytotoxics

Side effects common to most cytotoxic drugs include: oral mucositis, tumour lysis syndrome (a particular risk in ALL and AML if white counts are high or there is bulky disease), hyperuricaemia, nausea and vomiting, bone marrow suppression, alopecia, reproductive toxicity and thromboembolism.[7] All cytotoxics are contraindicated during pregnancy. Drug interactions are common and widespread – see BNF for details.

Anthracyclines

The anthracyclines doxorubicin, daunorubicin and idarubicin are cardiotoxic, with high cumulative doses potentially causing cardiomyopathy and heart failure. Doxorubicin and idarubicin are contraindicated in patients with severe myocardial insufficiency, recent myocardial infarction and severe arrhythmias. Side effects include cardiac disorders, extravasation, elevated bilirubin, diarrhoea and red coloration of the urine.

Alkylating agents

Key problems with the prolonged use of alkylating agents are impaired gametogenesis and increased risk of acute non-lymphocytic leukaemia (especially when combined with excessive irradiation).

Rarely, chlorambucil can cause widespread rashes that may progress to Stevens-Johnson syndrome or toxic epidermal necrolysis. If a rash occurs, it should be substituted for cyclophosphamide. Chlorambucil should be used cautiously in patients with a history of epilepsy and children with nephrotic syndrome, and avoided in acute porphyria.

Side effects of cyclophosphamide include anorexia, cardiotoxicity at high doses, interstitial pulmonary fibrosis, inappropriate secretion of diuretic hormone, disturbances of carbohydrate metabolism, urothelial toxicity, and pigmentation of palms, nails and soles. A urinary metabolite of cyclophosphamide can cause haemorrhagic cystitis – increased fluid intake for 24-48 hours after intravenous injection is recommended. Cyclophosphamide is contraindicated in haemorrhagic cystitis and caution is required in acute porphyria and renal or hepatic impairment.

Antimetabolites

Cytarabine is a potent myelosuppressive and requires haematological monitoring.

Fludarabine has a powerful and prolonged immunosuppressive effect. Co-trimoxazole is used to prevent pneumocystis infection and only irradiated blood products can be given (to avoid graft-versus-host reaction). Immune-mediated haemolytic anaemia, thrombocytopenia and neutropenia are less common side effects. Monitoring is required for signs of haemolysis, neurological toxicity and skin cancer. Fludarabine is contraindicated in haemolytic anaemia.

Methotrexate causes myelosuppression, mucositis and rarely pneumonitis. It is contraindicated in severe renal or hepatic impairment and pleural effusion or ascites. Concomitant folic acid can reduce side effects.

Vinca alkaloids

Neurotoxicity – typified by peripheral paresthesia, loss of deep tendon reflexes, abdominal pain, constipation or ototoxicity – is a limiting side effect of vincristine. Vincristine can cause severe local irritation, extravasation and bronchospasm.

Tyrosine kinase inhibitors (TKIs)

Side effects of TKIs include diarrhoea, elevated transaminases, hypophosphataemia, muscle cramps, nausea and vomiting, periorbital or peripheral oedema, pleural effusion, QTc prolongation and skin rash. Imatinib should be used cautiously in cardiac disease, with monitoring of fluid retention and liver function.

Dasatinib may cause severe neutropenia and thrombocytopenia in up to 50 per cent of patients.[1] Nilotinib is less myelosuppressive but associated with biochemical abnormalities such as elevated bilirubin, transaminases and lipases. Caution should be exercised in patients susceptible to QT-interval prolongation.

Metabolism of TKIs is primarily via the cytochrome P450 CYP3A4 so enzyme inducers (eg rifampicin and phenytoin) and inhibitors (eg itraconazole, clarithromycin, grapefruit juice) should not be given concurrently.[1]

ATRA

ATRA is generally well tolerated but can cause retinoic acid syndrome – a serious adverse event characterised by fever, fluid retention, low blood pressure and dyspnoea.

Monoclonal antibodies

The main adverse effects with rituximab and alemtuzumab are infusion-related reactions, usually occurring during the first intravenous administration. Symptoms include fever and chills, nausea and vomiting, allergic reactions, flushing and tumour pain. Premedication with analgesic, antihistamine and corticosteroid is recommended.

Other rare but serious side effects of rituximab include neutropenia, leucopenia, infection and cardiovascular events.[6] Progressive multifocal leucoencephalopathy (a rare and often fatal viral disease causing damage to the white matter of the brain) has also been reported and warrants close cognitive, neurological and psychiatric monitoring.

Rituximab should be used with caution in patients on cardiotoxic chemotherapy or with a history of cardiovascular disease due to the risk of exacerbating angina, arrhythmia or heart failure.

Compliance

Leukaemia treatment involves powerful drugs that bombard and batter the body, eliciting a whole host of unwanted effects. Maintaining compliance with the treatment plan can therefore prove extremely challenging. Pharmacists have an important role to play minimising and managing these medication side effects, offering lifestyle advice and self-help measures to help patients obtain maximum benefit from treatment. See table 1, online at www.chemistanddruggist.co.uk/update in the full version of this article, for possible side effects and management options.

Nausea and vomiting are among the most infamous of chemotherapy side effects and can cause considerable distress, sometimes leading to refusal of further treatment. Effective prophylaxis strategies are therefore vital. Certain patients will show increased susceptibility to emesis including women, patients under 50 years of age, anxious patients and sufferers of motion sickness. Pharmacotherapy choices will depend on whether the symptoms are acute (occurring within 24 hours of treatment), delayed (onsetting after 24 hours) or anticipatory (experienced prior to subsequent doses):[7]

- Acute: patients at low emesis risk – domperidone or metoclopramide, with dexamethasone or lorazepam as additional options; high-risk patients – a specific serotonin antagonist (given orally) in combination with dexamethasone.
- Delayed: oral dexamethasone, alone or in combination with metoclopramide or prochlorperazine.
- Anticipatory: lorazepam is good for its amnesic, sedative and anxiolytic effects.

Table 1, further information and references are available online in the full version of this article at www.chemistanddruggist.co.uk/update

Helen Boreham is a freelance medical writer with an MSci in medicinal chemistry.

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online (p20). ►►

NEXT WEEK
Update looks at the role of pharmacists in treating cystitis

Mucus cough – are you aware of the problem?

Mucus congestion affects more customers than you may realise

- One study showed that up to 63% of the UK population suffer from chest congestion and mucus build up[1]

Clearing Mucus really matters

- Mucus is secreted in the lungs, sinuses and nose and has protective, lubricating and disease preventing properties
- During a cold, mucus production is increased and may overwhelm normal clearance mechanisms
- Initially, the mucus is thin and watery, but in chesty coughs, mucus may become thicker

Opportunity to fill an unmet consumer need in the cough category

- The Benylin Mucus Cough range thins and loosens chest mucus to help make a cough more productive, helping relieve the weighty, uncomfortable feeling of mucus on the chest

NEW

- Nothing is more powerful for mucus cough
- Works deep down to clear bronchial congestion
- Makes cough more productive

- A max strength, unique formula you can really feel
- Thins and loosens chest mucus
- Immediate menthol sensation and invigorating taste

- Convenient two in one remedy
- Helps relieve nasal congestion fast
- Thins and loosens chest mucus

- Aids restful sleep
- Soothes and relieves night-time cough
- Helps clear a blocked nose

To order free eye catching winter POS materials while stocks last, phone 0808 238 9783 and quote 'P2846'

McNeil Products Ltd

Get it off your chest Benylin®

Benylin Mucus Cough Product Information:
Presentation: Red syrup containing 100 mg Guaifenesin and 1.1 mg Levomenthol per 5 ml. **Uses:** Symptomatic relief of cough. **Dosage:** Adults and children over 12 years: 10 ml four times daily. **Contraindications:** Known hypersensitivity to ingredients. Use in children under 12 years. **Precautions:** Do not use in persistent or chronic cough, e.g. asthma, or cough accompanied by excessive secretions; caution in severe renal or hepatic impairment. **Pregnancy and Lactation:** Consult doctor. **Side effects:** Very rare. **RRP (ex-VAT):** 150ml £4.33; 300ml £6.37 **Legal category:** GSL. **PL Holder:** McNeil Products Ltd, Foundation Park, Maidenhead, Berks, SL6 3UG. **PL No:** 15513/0056. **Date of prep:** June 2010.

Benylin Mucus Cough Menthol 100mg/5ml Syrup Product Information:
Presentation: Red syrup containing 100 mg Guaifenesin per 5 ml. **Uses:** Symptomatic relief of cough. **Dosage:** Adults and children over 12 years: 10 ml four times daily. Not recommended in children under 12 years. **Contraindications:** Known hypersensitivity to ingredients. **Precautions:** Do not use in persistent or chronic cough, e.g. asthma, or cough accompanied by excessive secretions; caution in severe renal or hepatic impairment; rare hereditary problems of fructose intolerance, glucose galactose malabsorption or sucrose-isomaltase insufficiency. **Pregnancy and Lactation:** Consult doctor. **Side effects:** Very rare. **RRP (ex-VAT):** 150ml £4.33. **Legal category:** GSL. **PL Holder:** McNeil Products Ltd, Foundation Park, Maidenhead, Berks, SL6 3UG. **PL No:** 15513/0165. **Date of prep:** July 2010

Benylin Mucus Cough plus Decongestant Syrup Product Information:
Presentation: Orange-red syrup containing 100 mg Guaifenesin and 30mg Pseudoephedrine per 5 ml. **Uses:** Symptomatic relief of upper respiratory tract disorders with productive cough. **Dosage:** Adults and children over 12 years: 10 ml four times daily. **Contraindications:** Known hypersensitivity to ingredients; severe hypertension; severe coronary artery disease; with or within 2 weeks of receiving MAOIs; use in children under 12 years. **Precautions:** Mild to moderate hypertension, heart disease, diabetes, hyperthyroidism, increased intraocular pressure, prostatic enlargement, severe hepatic impairment, renal impairment. Do not use in persistent or chronic cough, such as occurs with asthma, or where cough is accompanied by excessive secretions. Not to be taken with any other cough or cold medicine. **Interactions:** Anti-hypertensive agents, tricyclic antidepressants and other sympathomimetic drugs, bretylium, betanidine, guanethidine, debrisoquine, methyldopa, alpha and beta blockers. **Pregnancy and Lactation:** Consult doctor. **Side effects:** Symptoms of CNS excitation including sleep disturbance and rarely hallucination, skin rashes and occasionally urinary retention. **RRP (ex-VAT):** 100ml: £2.97. **Legal category:** P. **PL Holder:** McNeil Products Ltd, Foundation Park, Maidenhead, Berks, SL6 3UG. **PL No:** 15513/0022. **Date of prep:** June 2010

Benylin Mucus Cough Night Product Information:
Presentation: Red syrup containing 100 mg Guaifenesin, 1.1 mg Levomenthol and 14mg Diphenhydramine per 5 ml. **Uses:** Night-time relief of cough, associated congestive symptoms and aiding restful sleep. **Dosage:** Adults, the elderly and children over 12 years: 10ml at bedtime followed by 10ml every 6 hours. Do not take more than 20ml in 24 hours. Children under 12 years: contraindicated. **Contraindications:** Known hypersensitivity to ingredients. Not for use in patients taking, or who have taken in the last 2 weeks, MAOIs. Children under the age of 12 years. **Precautions:** Do not use in persistent or chronic cough, e.g. asthma, or cough accompanied by excessive secretions, unless directed by a doctor; caution in moderate to severe renal or hepatic impairment, and in narrow-angle glaucoma or prostatic hypertrophy. Avoid alcohol. Diphenhydramine may potentiate effects of alcohol, codeine, antihistamines, other CNS depressants, and may potentiate effects of anticholinergics e.g. psychotropic drugs and atropine. **Pregnancy and Lactation:** Consult doctor before use. **Side effects:** Diphenhydramine may cause drowsiness, dizziness, gastrointestinal disturbance, dry mouth and throat, difficulty in urination or blurred vision. Less frequently it may cause palpitations, tremor, convulsions or paraesthesia. Hypersensitivity reactions have been reported, in particular, skin rashes, erythema, urticaria and angioedema. Gastrointestinal discomfort, nausea and vomiting have been reported with guaifenesin, particularly in large doses. **RRP (ex-VAT):** 150ml £4.33 **Legal category:** P. **PL Holder:** McNeil Products Ltd, Foundation Park, Maidenhead, Berks, SL6 3UG. **PL No:** 15513/0050. **Date of prep:** June 2009

Reference:
1. Source: Brain Juicer Concept Optimizer – September 2008

Date of preparation: October 2010 ID: 06181

Leukaemia: part 2

What does Nice recommend for the treatment of CML? What are the side effects of anthracyclines? How are the side effects of chemotherapy such as sickness and nausea managed?

This article describes the treatment of the different types of leukaemia and includes information about cautions, contraindications and side effects of the drugs that are used. The management of side effects such as nausea and vomiting and sore mouth are also discussed.

- Find out more about the side effects and contraindications of cytotoxic drugs from section 8.1 in the BNF.
- Read more about stem cell transplant on the Patient UK website at http://tinyurl.com/leukaemia04.
- Read the information about sore mouth and taste changes on the Cancer Research website at http://tinyurl.com/leukaemia05.
- The Cancer Research website also has some useful advice for patients suffering from nausea and vomiting at http://tinyurl.com/leukaemia06.

Are you now confident in your knowledge of the drugs used to treat leukaemia? Could you advise patients about how to cope with sore mouth and nausea and vomiting due to chemotherapy?

5 minute test
What have you learned?

Test yourself in three easy steps:

Step 1

Register for Update 2010 and receive a unique PIN number

Step 2

Access the 5 Minute Test questions on the C+D website at **www.chemistanddruggist.co.uk/mycpd**

Step 3

Use your PIN to complete the assessment online. Your test score will be recorded. If you successfully complete the 5 Minute Test online, you will be able to download a CPD log sheet that helps you complete your CPD entry at www.ucpdate.org.uk

Registering for Update 2010 costs £37.60 (inc VAT) and can be done easily at www.chemistanddruggist.co.uk/update or by calling 0207 921 8425.

Signing up also ensures that C+D's weekly Update article is delivered directly to your inbox free every week with C+D's email newsletter.

Get a CPD log sheet for your portfolio when you successfully complete the 5 Minute Test online.

Practical Approach

What's causing this blackened tongue?

At the Update Pharmacy, senior medicines counter assistant Hannah comes into the dispensary and says to pharmacist David Spencer: "David, there's a man out in the shop poking his tongue out at the girls – and it's not a pretty sight! I think he might be high on something."

"OK, I'll sort it out," says David and goes out into the shop where he is confronted by a man poking his tongue out at him.

"Excuse me, sir," the man says, "can you sort this out for me?"

David has a quick look at the man's tongue. The central portion is blackish in colour and the papillae enlarged.

"I'll try, and you can put your tongue back in now," David replies. "Have you had this problem for long and does it hurt at all?"

"I've had it about a week. It doesn't hurt."

"Tell me," David continues, "do you smoke or drink?"

"I have the odd ciggie and a little drink now and again. But God's truth, neither to excess."

"Do you take drugs?"

"Only what the doc prescribed."

"Do you know what they are?"

The man fishes out of his pocket crumpled packets of olanzapine, lithium carbonate and valproate tablets.

"Do you take these regularly?" David asks.

"Oh yes, sir – when I remember."

"For how long?"

"These two," says the man holding out the lithium and valproate, "for a long time, sir. This one," he says, pointing to the olanzapine, "just about a month, sir."

Questions

1. What is this man's condition likely to be?
2. What are the potential causes or contributory factors? What is the most likely cause in this case?
3. What is the treatment?

Answers

1. Black hairy tongue (BHT), a benign, usually symptomless self-limiting disorder, characterised by abnormally hypertrophied and elongated filiform papillae on the surface of the tongue, usually accompanied by a black or brownish discoloration. BHT is caused by defective desquamation of the dorsal surface of the tongue, which prevents normal debridement. The overgrown papillae collect debris, bacteria, fungi or other foreign materials, contributing to the discoloration and possibly also to taste alterations, nausea, halitosis, and pain or burning of the tongue.

2. These include smoking, alcohol, chronic dry mouth (xerostomia), poor oral hygiene, drugs of abuse (particularly smoking drugs such as crack cocaine), oxidizing mouthwashes (eg hydrogen peroxide), recent radiation therapy, trigeminal neuralgia, cancer, AIDS, prescribed drugs. The latter include antibiotics, xerostomia-inducing drugs (antimuscarinics, antidepressants, antihypertensives), bismuth and olanzapine (the most likely cause in this case).

3. Identification and removal of any inducing drug. Meticulous oral hygiene and cessation of modifiable predisposing factors (eg smoking, oxidizing mouthwashes). Brushing or scraping of the tongue. There are several pharmacological treatments, including topical 50 per cent trichloroacetic acid, antifungals, triamcinolone acetonide, 40 per cent urea solution, gentian violet, salicylic acid, vitamin B complex, thymol, salicylic acid, and topical or oral retinoids (eg isotretinoin), all with only anecdotal evidence of effectiveness. As a last resort, the papillae can be clipped or removed by carbon dioxide laser burning or electrodesiccation.

Further reading

- Thompson DF, Kessler TL. Drug-Induced Black Hairy Tongue. Pharmacotherapy 2010;30:585-593.

A Night to remember

NEW Kalms Night One-A-Night is a one tablet dose formulation that gives your customers a simple way to promote refreshing natural sleep. And with a £1.1million campaign ready to support both Kalms Sleep and Kalms Night One-A-Night, we're confident that the only thing that won't be dropping off is your profits. Make sure you're stocked up!

For further information please visit:
www.kalmsnight.com or call **01452 507458**

Lanes HEALTH

Kalms Night is a traditional herbal medicinal product used for temporary sleep disturbances exclusively based on long standing use as a traditional remedy.

Indications: Kalms Sleep: A traditional herbal medicinal product used to promote natural sleep. Kalms Night: A traditional herbal medicinal product used for the temporary relief of sleep disturbances, based on traditional use only. **Active Ingredients:** Kalms Sleep: Dry extract from Valerian root (Valeriana officinalis L.) equivalent to 180mg. Extraction solvent: Ethanol 60%V/V – 45mg/tablet, dry extract from Passion Flower herb (Passiflora incarnata L.) equivalent to 90mg of Passion Flower herb. Extraction solvent: Ethanol 60%V/V – 16.82mg/tablet, Dry extract from Wild Lettuce leaf (Lactuca virosa L.) equivalent to 90mg of Wild Lettuce leaf. Extraction solvent: Methanol 50%V/V – 22.5mg/tablet, Hop strobiles (Humulus lupulus L.) – 30mg/tablet Verbena Herb (Verbena officinalis L.) – 60mg/tablet. Kalms Night: Dry extract from Valerian root (Valeriana officinalis L.) equivalent to 1.5-2.5g of Valerian root. Extraction solvent: Ethanol 60%V/V – 500mg/tablet. **Usage:** For oral use. Kalms Sleep: Adults: Swallow 3 or 4 tablets one hour before bedtime. As treatment effects may not be apparent immediately, Kalms Sleep should be taken for 2-4 weeks continuously. Kalms Night: Adults and the elderly: One tablet to be taken 30-60 minutes before bedtime. One additional tablet can be taken earlier during the evening if necessary. As treatment effects may not be apparent immediately, Kalms Night should be taken for 2-4 weeks continuously. **Side Effects, precautions & relevant contra-indications:** Kalms Sleep & Kalms Night: May cause nausea or abdominal cramps. Not to be taken if allergic to any of the ingredients. Do not exceed stated dose. Not recommended for anyone under 18 years old. Not recommended for use during pregnancy or when breast-feeding. Contact a doctor if symptoms worsen or do not improve after 4 weeks. May cause drowsiness. If affected, do not drive or operate any tools or machines. Alcohol may increase the sedative effect. Excessive alcohol consumption should be avoided. Kalms Night: Do not take if you are taking any other medicine for sleep. **PL holder:** G. R. Lane Health Products Limited, Sisson Road, Gloucester, GL2 0GR United Kingdom. **GSL. RSP:** Kalms Sleep: £3.82 for 50 tablets. Kalms Night: 21 tablets, £4.99. **PL no:** Kalms Sleep: PL 01074/0026. Kalms Night: THR 01074/0002

C+D Senate LIVE

After recent category M cuts and with NHS reforms ahead, the C+D Senate asks: could a new funding model secure pharmacy's future? **Hannah Flynn** reports

THE C+D SENATE
IN ASSOCIATION WITH actavis

The community pharmacy think-tank

TOPIC: **A new funding model for England**

Funding was high on the agenda for many pharmacists in the audience at the first C+D Senate Live, held at the Pharmacy Show this month, and many were keen to highlight to the expert panel where they thought they were losing out.

Senators agree that the way pharmacists are reimbursed needs to be reviewed – and that pharmacists need to choose between focusing on reimbursement for prescription volume and paid clinical services.

Debate was sparked when independent pharmacist Graham Phillips suggested that GPs had too much influence on his personal income. Mr Phillips asked the Senators: "My professional income within the current contract relies on which particular generic my GP prescribes. Is the current contract a busted flush?"

Senator and CCA chief executive Rob Darracott agrees it is odd that the income of pharmacists is "dependent on the random actions and thoughts of another profession". He asks why the industry has not made more of a fuss about it.

Mr Darracott says: "It is not just about what generic they prescribe, it is about how long they want to write a prescription for and if pharmacy remuneration is affected by whether a local surgery issues a 28-day repeat or a 56 or even 84. I think it is surprising we haven't got more bothered about that."

He adds: "I think for too long we have been waiting to hear what other professions are doing and thinking, and we need to collectively do a lot more about that."

Other Senators agree, but the Department of Health's national clinical director for pharmacy Jonathan Mason points out that GPs might be more receptive to change than pharmacists think. Referring to meetings he has held with leaders from GP bodies, he says that these changes are likely to be welcomed.

He explains: "I have heard it said, by a couple of GP leaders, that the FP10 should be seen as a referral to the pharmacist. It should say, 'Start this medicine, you decide the way of managing this patients' condition.'

"The prescription should be a referral to say: if the patient needs weekly dispensing, fine, if they need 28-day then fine, but whatever works for the patient."

One major flaw in the system pointed out by Senators is the role of GP receptionists in preparing prescriptions. Mr Mason says pharmacists must say it is wrong that GP surgeries are using "an untrained or barely trained receptionist" to issue prescriptions.

The debate about pharmacy remuneration models is of course taking place against a recession, and Mr Mason points out that the financial landscape will only get tougher, as the coalition government looks to cut public spending.

According to Mr Mason, £15-20 billion must be made in efficiency savings by the end of 2014, and "medicines are going to play huge part in that".

Though it is agreed that times are tough and pharmacists appear to have less influence over their fortunes than they would like, the Senators have many ideas about how the industry could claw back control of its finances.

RPS English Pharmacy Board chair Lindsey Gilpin is quick to point out that pharmacists in England and Wales are the envy of Europe as they are being paid to provide MURs. Ms Gilpin says that UK pharmacists must move forward with what they already have, but adds that the RPS national boards envision pharmacists becoming more involved in medicines management.

She says: "The Pharmaceutical Society has the vision of [the pharmacist] being the person in charge of medicine. So you get the prescription, maybe for diabetes or heart problems, you get some medicine for this gentlemen and then make

The Senators

Left to right:

Jonathan Mason
National clinical director for pharmacy, Department of Health

Michael Cann
Chairman, BGMA

Ian Facer
Chairman, NPA

Lindsey Gilpin
Chair, English Pharmacy Board, RPS

Rob Darracott
Chief executive, CCA

Sue Sharpe
Chief executive, PSNC

sure that it is suitable on an ongoing basis. That's our long-term vision, but you have to start somewhere on that clinical pathway and it must be funded. It is something we think should be funded centrally to avoid this postcode lottery that is PCTs."

This would mean a move away from volume and towards being paid for a role in clinical care, Ms Gilpin emphasises.

Comparing this to the current situation in Scotland, Mr Mason adds: "Following it up, including everything up to MURs and medicines review, is part of a continuum we have seen in Scotland with their chronic medication service and we need to look at something similar in England."

BGMA chairman Michael Cann agrees with the solutions put forward by other Senators, but says that there are also many short-term changes that could be implemented in pharmacy.

Firstly, branded generic prescribing should go. "That's a day one action that should be sorted out," Mr Cann says. "It is biting into your profit margins, it is making a mess of the system and

actually we should get rid of it as soon as possible."

Secondly, the rules regarding pack sizes need to be reviewed, he adds. "We need to get rid of this anomaly surrounding pack sizes that makes it slightly chaotic for dispensing pharmacists to have to remember which product should be dispensed in which pack size. And, though I think it is good to look at the longer term action, there are some great short-term wins which I think should just be sorted out."

Senator and PSNC chief executive Sue Sharpe agrees there is a need for urgency, and that changes to the services and remuneration model need to be made in the next three to four years, after taking into account the time needed to retrain and upskill pharmacy staff.

Mrs Sharpe explains: "Pharmacy needs to be in a position of having these services related to medicines, and health and wellbeing services, well bedded in. And I think we need to be making our pitch to do that in the next six months."

And NPA chairman Ian Facer says that for any of these changes to be made it is imperative that pharmacists decide which path they want to take, and whether this is clinical or surrounding prescription volume.

Regarding a more clinical role, Mr Facer says: "Upwards of a third of you are saying that you don't want to take that journey and that is an inherent problem if that is the case."

Next, Mr Facer says, a lot of work is needed to enable the changes proposed by the Senate.

"We then need to put in place the enablers that enable us to carry that [plan] forward, and that is about remuneration frameworks, it is about training, it is about IT and infrastructure, it is about integration with the health service in general, about the legislative framework that works around it, and – dare I say it – supervision, which is one of the enablers that we need to do, and it is about good practice. We need to pick up on good practice."

Mr Facer emphasises that pharmacy needs a more coherent voice from its representative bodies if it is to make these radical changes. This is not currently the case, Mr Facer says.

"I'll give you an excellent example. We have been speaking about the white paper [and] there's at least four responses and they all largely say the same thing. Why are we doing that?" he asks.

Senators agree that pharmacy needs to develop its clinical role and be paid for providing these services. They also agree that the role of the community pharmacist needs to become more prominent in primary care.

It is clear, however, that plans for these changes must be made now and if the industry cannot manage to impress this on the NHS, as it undergoes the widest-ranging changes since its creation, then the sector may miss the boat entirely.

The Senate Ruling

1. **Pharmacists must play a more prominent clinical role.**
2. **A definite plan for the future of pharmacists as clinicians must be made in the next six months and presented to government.**
3. **Branded generic prescribing needs to be reviewed.**
4. **Pharmacy bodies need to avoid duplicating their messages regarding funding.**

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on the contract

REFLECT	Do I understand how the contract affects my pharmacy and the service I provide patients?
PLAN	Consider how commissioning and contract changes could affect my pharmacy and the services it offers.
ACT	Read relevant sections of the NHS white paper on the future of commissioning
EVALUATE	Do I better understand how changes to the contract and local commissioning could affect patient services?

CATEGORY FOCUS

Weight management

Widen your range and link products to advice to make the most of the £70m slimming aid market, says Kathy Oxtoby

Obesity rates in the UK are soaring, with nearly a quarter of adults now classed as clinically obese. Despite government warnings about the risks of obesity-related illnesses – such as diabetes, cancer and heart disease – waistlines continue to expand. According to the Department of Health, this could cost the NHS in England as much as £6.3 billion a year by 2015.

There is a correspondingly large market in slimming aids – worth almost £70m, according to SymphonyIRI Group. Key subcategories in the slimming aids market, figures from the data analyst suggest, include: meal replacement bars, which grew by almost 30 per cent, and powder formats, where pharmacy has boosted its share by over 90 per cent.

From soups to smoothies and herbal supplements to pharmacy-only medicine Alli, customers have never had so many options when it comes to products to help them lose weight. But so much choice can be daunting, which is where pharmacists can help.

Market positioning

"Every customer is different," says Shafeeque Mohammed, senior healthcare development manager for Lloydspharmacy. "A range of services or products should be made available, but communicated in a way that the customer understands and can, with advice from the pharmacist, make an informed decision."

A common mistake made by pharmacists is having an insufficient weight management product range, says Numark director of marketing Lynne Henshaw.

"You need to create a category – one or two products won't do," she explains. "And you need to create theatre around the category, from window to counter. It's important to demonstrate your expertise in this area and depth of range is one aspect of communicating this."

Subcategories should be organised so customers can distinguish between meal replacements and weight loss aids, while P treatments such as Alli should be clearly signposted behind the counter, adds Boots pharmacist Angela Chalmers.

And Ms Henshaw advocates that the slimming aids section should be placed near GSL medicines, warning: "Instinct tells you to display them near the window so people can see them, but many of these products are high-priced and could be subject to pilfering."

Siting near GSL medicines also puts slimming aids within easy reach of pharmacy staff, she suggests. This means staff should be able to engage customers in conversation about the products if they sense an interest, rather than approaching directly, which could signal to the customer that they have been targeted because they look overweight.

In fact, one of the best ways to help customers get the most out of the slimming aids market and increase sales is to ensure staff are well-trained and knowledgeable about

Market changes 2009-10 Slimming aids

Total market value		
£68,167,780	▲	0.9%
Pharmacy*		
£11,766,420	▲	1.9%
Grocery **		
£56,176,570	▲	1.6%

*Excluding Boots and Superdrug
**Including Boots and Superdrug

Best-selling slimming aid brands

1. Slimfast
2. Alli
3. Adios
4. Atkins
5. Own label

Source: SymphonyIRI Group value sales, 52 weeks to September 4, 2010

SymphonyIRI Group
Insight. Innovation. Impact.

New licensed liquid Simvastatin. A heartfelt solution for patients who can't swallow tablets.

New licensed liquid Simvastatin is effective and easy to take. Many statin patients fail to take their medication regularly,[1] making an effective treatment, ineffective.[2]

One common problem is difficulty with swallowing,[1] so Rosemont have launched the only licensed liquid Simvastatin as an easy to swallow alternative. Pleasant tasting and in a choice of strengths it is a welcome solution for patients who are unable to swallow tablets.

Abbreviated Prescribing Information. SIMVASTATIN 20mg/5ml and 40mg/5ml Oral Suspension. Consult Summary of Product Characteristics before prescribing. Presentation: White to off-white oral suspensions. **Therapeutic Indications:** Hypercholesterolaemia: Treatment of primary hypercholesterolaemia or mixed dyslipidaemia, as an adjunct to diet, when response to diet and other non-pharmacological treatments is inadequate. Treatment of homozygous familial hypercholesterolaemia as an adjunct to diet and other lipid-lowering treatments or if such treatments are not appropriate. Cardiovascular prevention: Reduction of cardiovascular mortality and morbidity in patients with manifest atherosclerotic cardiovascular disease or diabetes mellitus, with either normal or increased cholesterol levels, as an adjunct to correction of other risk factors and other cardioprotective therapy. **Posology and Method of Administration:** *Adults:* The dosage range is 5 – 80mg/day depending on condition given orally as a single dose in the evening. Adjustments of dosage if required, should be made at intervals of not less than 4 weeks, to a maximum of 80mg/day given as a single dose in the evening. The 80mg dose is only recommended in patients with severe hypercholesterolaemia and high risk for cardiovascular complications. No modification of dosage should be necessary in patients with moderate renal insufficiency. In patients with severe renal insufficiency, dosages above 10mg/day should be carefully considered. *Children:* (10–17 years of age, boys Tanner Stage II and above and girls who are at least one year post-menarche) with heterozygous familial hypercholesterolaemia, starting dose is 10mg once a day in the evening. The recommended dosing range is 10–40 mg/day. Adjustments should be made at intervals of 4 weeks or more. The experience of simvastatin in pre-pubertal children is limited. *Elderly:* No dosage adjustment is necessary. **Contra-indications:** Hypersensitivity to simvastatin or to any of the excipients. Active liver disease or unexplained persistent elevations of serum transaminases. Pregnancy and lactation. Concomitant administration of potent CYP3A4 inhibitors. **Precautions:** Myopathy/Rhabdomyolysis. Hepatic effects: persistent increases (to > 3 x ULN) in serum transaminases have occurred in a few adult patients who received simvastatin. When simvastatin was interrupted or discontinued in these patients, the transaminase levels usually fell slowly to pre-treatment levels. The product should be used with caution in patients who consume substantial quantities of alcohol. Interstitial lung disease: exceptional cases of interstitial lung disease have been reported with some statins, especially with long term therapy. Excipient Warnings: parahydroxybenzoates, which may cause allergic reactions. **Interactions:** The risk of myopathy including rhabdomyolysis is increased during concomitant administration with fibrates. There is a pharmacokinetic interaction with gemfibrozil resulting in increased simvastatin plasma levels. Rare cases of myopathy/rhabdomyolysis have been associated with simvastatin co-administered with lipid-modifying doses (≥1 g/day) of niacin. Drug interactions associated with increased risk of myopathy/rhabdomyolysis: Potent CYP3A4 inhibitors – Contraindicated with simvastatin. Gemfibrozil – Avoid but if necessary, do not exceed 10mg simvastatin daily. Ciclosporin, danazol, other fibrates (except fenofibrate) – Do not exceed 10mg simvastatin daily. Amiodarone, verapamil – Do not exceed 20mg simvastatin daily. Diltiazem – Do not exceed 40mg simvastatin daily. Fusidic acid – Patients should be closely monitored. Grapefruit juice – Avoid grapefruit juice when taking simvastatin. Effects of other medicinal products on simvastatin: Combination with itraconazole, ketoconazole, HIV protease inhibitors, erythromycin, clarithromycin, telithromycin and nefazodone is contraindicated. Ciclosporin – the dose of simvastatin should not exceed 10mg daily. Very rare cases of elevated INR have been reported. **Pregnancy and Lactation:** Simvastatin Oral Suspension is contraindicated during pregnancy. It is not known whether simvastatin or its metabolites are excreted in human milk. Women taking Simvastatin Oral Suspension should not breast-feed their infants. **Effects on Ability to Drive and Use Machines:** Simvastatin Oral Suspension has no or negligible influence on the ability to drive and use machines. **Undesirable Effects:** Investigations: Rare: increases in serum transaminases, elevated alkaline phosphatase, increase in serum CK levels. Blood and lymphatic system disorders: Rare: anaemia. Nervous system disorders: Rare: headache, paresthesia, dizziness, peripheral neuropathy. Very rare: memory impairment. Gastrointestinal disorders: Rare: constipation, abdominal pain, flatulence, dyspepsia, diarrhoea, nausea, vomiting, pancreatitis. Skin and subcutaneous tissue disorders: Rare: rash, pruritus, alopecia. Musculoskeletal, connective tissue and bone disorders: Rare: myopathy, rhabdomyolysis, myalgia, muscle cramps. General disorders and administration site conditions: Rare: asthenia. Hepato-biliary disorders: Rare: hepatitis/jaundice. Very rare: hepatic failure. Psychiatric disorders: Very rare: insomnia. **Overdose:** There is no specific treatment in the event of overdose. **Shelf Life and Storage:** [illegible] unopened, 1 month opened. Do not store above [illegible]. **Legal Category:** POM. **Pack Size and NHS Price:** 20mg/5ml [illegible] 150ml – £152.00. **Marketing Authorisation Holder:** Rosemont Pharmaceuticals Ltd, Rosemont House, Yorkdale Industrial Park, Braithwaite Street, Leeds LS11 9XE, UK. **Marketing Authorisation Number:** 20mg/5ml PL 00427/[illegible] 40mg/5ml [illegible]. **Date of Preparation:** May 20[illegible]

References: 1. Benner JS, Glynn RJ, Mogun [illegible] use of statin therapy in elderly patients. *JAMA* [illegible] [illegible] *Am Fam Physician* 200[illegible] **63** [illegible]

Rosemont

The source of liquid solutions

Rosemont Pharmaceuticals Ltd. Rosemont House, Yorkdale Industrial Park, Braithwaite Street, Leeds LS11 9XE **T** +44 (0)113 244 1400 **F** +44 (0)113 245 3567
E infodesk@rosemontpharma.com Sales/Customer Service: **T** +44 (0) 113 244 1999 **F** +44 (0) 113 246 0738 **W** www.rosemontpharma.com

Information about adverse event reporting can be found at www.yellowcard.gov.uk Adverse events should also be reported to Rosemont Pharmaceuticals Ltd on 0113 244 1400.

weight management, advises NetDoctor pharmacist Rita Ghelani. She suggests pharmacists could identify a particular member of staff with good communication and customer services skills to be a weight loss adviser.

As well as being able to offer expert guidance about the clinical aspects of products, pharmacy can also offer customers regular weight management support at a time that suits them.

"Local community pharmacists can be the first point of call for people who want to lose weight. We can tailor appointments to fit with their schedule and reassure them that we will support them all the way," says Anoop Mistry, Co-operative branch manager in Coalville, Leicestershire.

As weight loss is often an extremely sensitive subject for customers, Mr Mistry stresses the importance of promoting the consultation room as a place where they can discuss their issues in confidence.

"When a customer asks for weight loss information, I have a discussion with them in private about their views on losing weight. This helps me understand the patient better and what's best for them – whether it's meal replacements or tablets," he says.

Failure to adequately publicise weight management services is another common mistake, Ms Henshaw believes. Pharmacists can publicise their weight management services through their local GP surgery and hospital, Mr Mistry suggests.

Placing leaflets and posters advertising weight loss services and the value of a healthy lifestyle by the pharmacy counter can also prompt a conversation from customers who may feel too embarrassed or be reluctant to approach their pharmacist about their concerns, says Ms Chalmers.

When supporting customers to lose weight, pharmacists should stress the slimming aids are only part of solution, says Mr Mohammed.

"Customers shouldn't see weight loss products as a quick fix. Pharmacists should help them by setting realistic weight loss goals and providing lifestyle and healthy living advice in conjunction with using any product," he says.

So by stocking an extensive range of clearly displayed products and offering consistent support and expert advice, pharmacists can not only help tackle the obesity crisis but also empower individuals to reach their ideal weight – as well as boosting their own bottom line with retail and service income.

As Ms Henshaw says: "The pharmacist is able to counsel and mentor patients and this time spent with them is key in the success of the person losing weight. So a weight management service is crucial for both the patient and the pharmacy business."

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on weight management

REFLECT	Do my patients get the most out of weight management products?
PLAN	Review my and my staff's knowledge and sales protocols.
ACT	Read this article, review available products, consider weight management programmes where appropriate and arrange training as necessary.
EVALUATE	Do my patients get better weight management advice?

Case study

PRITCHARDS PHARMACY, WALSALL

The pharmacist manager reveals how Lipotrim has helped his customers shed pounds while boosting business

Walsall has a high percentage of obesity, so we wanted to see if we could help people manage their weight more effectively. This January, we decided to offer the Lipotrim programme. For a start-up cost of £200 it provides everything you need to support customers to lose weight, including online training resources.

The programme's products and those pharmacies that deliver the service are publicised on the internet, which is where we get our referrals from. We charge women £36 a week and men £48, and I spend around 30 minutes a week with patients, so the programme generates cash flow.

Lipotrim is a liquid diet, which is nutritionally complete, and patients take three or four sachets a day until they reach their target. When a patient first visits us to take part in the programme, we go through a medical screening form with them – which includes measuring their height and weight to work out their BMI. We also show them a DVD about the programme so they know what's involved.

We offer patients weekly support and advice, not only during the programme but also afterwards to help them maintain a healthy diet.

Weight loss for patients is dramatic. One lady on the diet lost 65lbs in just four months. Having tried every diet, she's delighted with her weight loss and says the only reason it worked is because she had weekly support from the pharmacy.

The programme has made a huge difference to business – we are around 10 per cent up on budget last year. I wasn't convinced this approach would be a success but have been proven wrong.

A further case study and Brand Watch are online at www.chemistanddruggist.co.uk/indepth

Jobs

Telephone 0207 921 8456

Booking and copy date
12 noon Monday prior
to Saturday publication
subject to availability

Contact: Dan Linton
Tel: 0207 921 8456
Fax: 0207 921 8132
dan.linton@ubm.com

Chemist+Druggist
Ludgate House
245 Blackfriars Road
London SE1 9UY

RECRUITMENT

PHARMACIST / PHARMACY MANAGER
MEDWAY, KENT

required for 5 day week plus alternate Saturday and Sunday.

Must have passion, commitment and people skills to develop volume and services.

Salary £36-40k (negotiable)

Please email CV to Mr Makinde at m.a.makinde@talk21.com

WILTSHIRE/BERKSHIRE BORDER
Rural General Medical Practice Requires

QUALIFIED DISPENSER/TECHNICIAN
Approx 18.5 hours per week

Communication and keyboard skills required along with the ability to work as part of a team. Additional hours available to cover holiday/sickness

Please email Alison.Harrod@gp-j83045.nhs.uk
or telephone 01672 520366 for an information pack

Closing date Monday 15th November 2010

Dr Owen-Jones & Partners, The Surgery, Whittonditch Road, Ramsbury, Marlborough, Wiltshire SN8 2QT

COURSES

PRE-REG VACANCY 2010 TILBURY, ESSEX

CHAPHARM CHEMIST

Accommodation available.

To apply please call 01375-859409 or email CV to chapharmtilbury@hotmail.co.uk

SUPERINTENDENT PHARMACIST
Hampshire

Join a new and rapidly expanding business contributing to the ongoing strategy of this new and exciting venture. You will manage and work in our new Internet Pharmacy on the outskirts of Basingstoke.

Mon to Fri. Salary Negotiable. Must be MUR accredited.

Apply with full CV via email to: info@surecalm.com

Marketplace

Telephone
0207 921 8456
Contact: Dan Linton
dan.linton@ubm.com

Postscript...

Family pharmacy wins award

Badham Pharmacy in Gloucestershire has won the Gloucester family business of the year award.

Pharmacist Peter Badham (pictured far right) says the company collected the award this month, which was presented at Cheltenham race course.

He says: "The judges were very impressed with the high-calibre service the company offers. We have provided a 24-hour service for many years as well as a free collection and delivery service.

"We offer free tests for cholesterol and diabetes. We have in-store opticians and a hearing test centre. We are at the forefront of patient care, providing new services in connection with the PCT."

Last week the company held a reopening ceremony at their Cheltenham branch, 70 years to the day after it opened.

Pam Smith (centre), who has been a patient at the pharmacy for 70 years, joined in the celebrations with Lyn and Peter Badham

A social tweet

Award entries via Twitter? Join the debate at www.twitter.com/chemistdruggist

@GaryParagpuri: Today I will be writing entry form for @ChemistDruggist Awards 2011 which will launch in one month.

@mark217: @GaryParagpuri Wlcm 2 Chmst&Drgst Awds 11 you could insist on entries via twitter. it would make judging quicker.

@GaryParagpuri: @mark217 Nt sr my bss wd apprve.

C+D reader of the week

Meet Rowlands pharmacy manager Lorraine Moore, who just wants to get away on her motorbike

What would you most want to contribute to the world? I would make sure that there were no disasters anywhere as there has been terrible flooding recently and the mining accident in Chile was tragic.

What has been the best thing about your day? We had a very good warfarin clinic, where everyone was in range.

What is the best idea you have ever had? To pass my motorbike test at the age of 33. I have two motor bikes and I take one into work in good weather.

Do you have a secret talent? It's not really a secret but I am quite sporty and I played hockey at league level. I was one stage away from national.

What would you do if someone gave you £1,000? I am decorating the lounge at the moment so a Bose sound system would be nice.

What's the strangest request you've ever had? You know your level of tolerance rises to strange requests so much that it becomes normal. We have had telephone queries about the sizes of condoms, but I think that is fairly standard.

What is your ideal holiday destination? I did 5,000 miles on my motorbike going around Europe this summer. I went to the Pyrenees and I want to go to the Alps and Croatia – anywhere on my bike really.

Who would be your ideal dinner party guest? A bit of Brad! Angelina could have the night off.

What should we ask our next reader? Do you think pharmacy prescribing should be incorporated into the degree course?

Calling all pharmacists and technicians. We want you to be our reader of the week. Email us at postscript@chemistanddruggist.co.uk

@The web hunter

I can shop online, bank online and can book a holiday online. And I can even find recipes for my favourite foods and then, if I can't be bothered to cook them myself, find out where I can go to eat them.

This, of course, isn't at all surprising given that it is the early 21st century and IP (internet protocol) has made electronic record sharing between banks, supermarkets and, more and more often between peers, as common on the information superhighway as potholes and contraflows are on Britain's roads.

It is good to see that the Coalition has appointed internet entrepreneur (and Telegraph columnist) Martha Lane Fox as UK digital champion. Ms Lane Fox, founder of Lastminute.com, intends to bring the last 10 million or so non-internet users kicking and screaming online under the government's Networked Nation plan.

And she claimed in her Telegraph column last week that the DH's consultation into how information technology can help patients take more control of their health shows real appetite for a shift towards Andrew Lansley's "No decision about me without me" ideal.

And well it might. For years the NHS has lagged behind the public sector in its use of information.

Tesco can look at what I buy and, based on Clubcard data, target me with offers that suit me and my shopping habits. In the same way, data from my central health file could be used to suggest better treatments, provide notice for health checks, etc.

In an ideal world, I wouldn't have to make a GP appointment if I thought it was time to have my prostate checked. Instead, if I popped to my local pharmacist for some OTC cough medicine they might ask me for my health card, which could then prompt the pharmacy to refer me for screening.

Now Ms Lane Fox doesn't, perhaps, go this far, but suggests patients shop around to get the best healthcare to suit them. She also suggests the problem with all of this is that healthcare doesn't work to a shared set of standards.

GPs use different systems, the take up of EPS 2 is severely lacking and, with people opting out of summary care records and its limited roll-out, a lot needs to be done before Ms Lane Fox's vision becomes reality.

Pharmacists wishing to take part in the consultations should visit: www.dh.gov.uk/en/Consultations/Liveconsultations/index.htm

Niall Hunt is C+D's digital content editor; email him at niall.hunt@ubm.com

FINANCIAL SERVICES

THOUSANDS OF RETAIL PHARMACISTS COULD CUT THEIR TAX BILLS BUT DON'T KNOW HOW!

- As the leading tax consultants to retail pharmacists we have clients throughout the UK.
- We know many pharmacists are happy with their accountants but are not getting proactive tax advice.
- We have the answer. You don't need to change accountants - we can work alongside them solving your tax problems and advising you how to reduce your tax bills.
- Some clients like a total service provider - others like to keep their existing accountant and just use our tax consultancy services.

"We are happy to work in the way that suits you"

Call us NOW to discuss how we can help you?
Phone Anne Hutchings on: **01494 722 224**

www.pharmacyexperts.com

h & Co.
Hutchings & Co.

The Leading Tax Consultants for Retail Pharmacists.

Maple House,
53-55 Woodside Road,
Amersham, Bucks
HP6 6AA

LEGAL SERVICES

the legal prescription

Cost effective specialist legal advice to independent retail and community pharmacies operating nationwide

We can assist with buying, selling, merging and demerging pharmacy businesses as well as related leases, sales and purchases of commercial premises

ANSONS LLP
Solicitors

Contact
Hilary D'Cruz or Jas Singh
01543 466 660
info@ansonsllp.com
www.ansonsllp.com

PRODUCTS & SERVICES

If you require a loan guarantee

Tel: 01928 750648

PHOENIX
Think

ARE YOU A LOCUM PHARMACIST?

modiplus provides the following compliance services at a fixed price:

- Preparation of annual accounts
- Preparation of tax returns
- Filing accounts and returns with the HMRC and Companies House
- Ensuring your accounts and tax returns are filed on time
- Registering you with the HMRC for self-employment status
- Help you with the purchase of pharmacy
- Ad hoc email and telephone advice with our friendly staff etc.

"I am very happy to have an accountant who is a locum specialist. By going into company, I have saved tax and the savings I made in the first year more than covers the accountant's fees."

JNJ LOCUM LTD, LONDON

For more information or for a FREE consultation please call Umesh on 020 7383 3200

modiplus™
ADDING VALUE

www.modiplus.co.uk

MEMBER OF SILVER LEVENE GROUP
AN ACCA REGULATED FIRM OF ACCOUNTANTS AND TAX ADVISERS SPECIALISING IN LOCUM PHARMACISTS

NEW POWERFUL CLINICAL EVIDENCE

No more treating head lice twice. With Hedrin Once Spray Gel and Liquid Gel, one treatment does the job.

A new clinical trial has shown that Hedrin Once Gel can kill 100% of lice and eggs in one 15 minute treatment[1]. No pesticides. No laborious combing. So now, there's really only one treatment to recommend.

15min **CLINICALLY PROVEN TO WORK IN JUST ONE 15 MINUTE TREATMENT[1]**

USE YOUR HEAD
USE YOUR HEDRIN

NOW, ONCE IS ALL IT TAKES